CMS Meaningful Use FAQs as of 12-12-12

For specific FAQs, click on a topic below:

Reporting Period

For the Medicaid Electronic Health Record (EHR) Incentive Program, if the EHR Reporting Period is calendar year (CY) 2013, then the payment year also refers to 2013 even though an eligible professional (EP) may receive the actual incentive payment in early 2014, correct? If this is the case, does "preceding year" mean that the number of patient encounters in any 90 day period in CY 2012 will be used? If so, why not use the number of patient encounters during CY 2013?

> The payment year is the year for which the payment is made (see 42 CFR 495.4 and the definition of "First, second, third, fourth, fifth, or sixth payment years."). So, the questioner is correct that if the EHR reporting period is in CY 2013, the payment year also refers to 2013. Using the patient encounters from the year preceding the payment year, when the EP is adopts, implements, or upgrades (AIU) certified EHR technology, or in the first year of demonstrating meaningful use, when the EHR reporting period is 90 days, allows the EP to receive an incentive early in the payment year, such as when their EHR reporting period occurs during the first 90 days of CY 2012).
> For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.
>
> Keywords: FAQ10102

Under the Medicaid Electronic Health Record (EHR) Incentive Program, if an eligible professional (EP) adopts, implements or upgrades to certified EHR technology (AIU) in January 2012 and gets the AIU payment in 2012, can the EP use a 90-day period in 2012 to report on EHR meaningful use (MU) for a 2013 Year 1 MU payment? Or, does the 90-day period have to be in the next calendar year 2013? Then they would have to show Year 2 MU in calendar year 2014 and not get their next incentive payment until sometime in 2015.

> First, it is important to note that when discussing 2013, CMS stated that it expects to engage in another cycle of rulemaking for that year. Under our current rules, the 90-day period has to be in the next calendar year 2013. Payment year is defined in 42 CFR 495.4 as a calendar year beginning with CY 2011, and for Medicaid, the first payment year is the first calendar year for which the EP receives an incentive payment. The second payment year is then the second calendar year for which the EP receives the incentive payment. Because each payment year is tied to a separate calendar year, and because for Medicaid, for the first year of demonstrating MU the EHR reporting period must be a continuous 90-day within the calendar year (with all subsequent years having an EHR reporting period equal to the full CY), the EHR reporting period must occur within the year of payment. Thus, the EHR reporting period is any 90-day period within CY 2013 in the example provided above. As for what stage of meaningful use the EP must show in CY 2014, CMS stated that it expects to engage in future rulemaking to address this issue.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10097

For the Medicaid EHR Incentive Program, how are the reporting periods for Medicaid patient volume and for demonstrating meaningful use affected if an eligible professional (EP) skips a year or takes longer than 12 months between attestations?

Regardless of when the previous incentive payment was made, the following reporting periods apply for the Medicaid EHR Incentive Program:
- For patient volume, an eligible professional (EP) should use any continuous, representative 90-day period in the prior calendar year.
- For demonstrating they are a meaningful users of Electronic Health Records (EHRs), EPs should use the EHR reporting period associated with that payment year (for the first payment year that an EP is demonstrating meaningful use, the reporting period is a continuous 90-day period within the calendar year; for subsequent years the period is the full calendar year).

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10528

What is the reporting period for eligible professionals (EPs) participating in the electronic health record (EHR) incentive programs?

For demonstrating meaningful use through both the Medicare and Medicaid EHR Incentive Programs, the EHR reporting period for an EP's first year is any continuous 90-day period within the calendar year. In subsequent years, the EHR reporting period for EPs is the entire calendar year. Under the Medicaid program, there is also an incentive for the adoption, implementation, or upgrade of certified EHR technology, which does not have a reporting period.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ9961

What is the reporting period for eligible hospitals participating in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program?

For an eligible hospital or critical access hospital's first payment year, the EHR reporting period is a continuous 90-day period within a Federal fiscal year. In subsequent years (except 2014), the EHR reporting period for eligible hospitals and critical access hospitals (CAHs) is the entire Federal fiscal year. In 2014, an eligible hospital or CAH can use either the entire Federal fiscal year or a 3-month period aligned with the quarters of the Federal fiscal year.

New ID #2715 Old ID #9962

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Location

For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, how should an eligible professional (EP), eligible hospital, or critical access hospital (CAH) that sees patients in multiple practice locations equipped with certified EHR technology calculate numerators and denominators for the meaningful use objectives and measures?

EPs, eligible hospitals, and CAHs should look at the measure of each meaningful use objective to determine the appropriate calculation method for individual numerators and denominators. The calculation of the numerator and denominator for each measure is explained in the July 28, 2010 final rule (75 FR 44314).

For objectives that require a simple count of actions (e.g., number of permissible prescriptions written, for the objective of "Generate and transmit permissible prescriptions electronically (eRx)"; number of patient requests for an electronic copy of their health information, for the objective of "Provide patients with an electronic copy of their health information"; etc.), EPs, eligible hospitals, and CAHs can add the numerators and denominators calculated by each certified EHR system in order to arrive at an accurate total for the numerator and denominator of the measure.

For objectives that require an action to be taken on behalf of a percentage of "unique patients" (e.g., the objectives of "Record demographics", "Record vital signs", etc.), EPs, eligible hospitals, and CAHs may also add the numerators and denominators calculated by each certified EHR system in order to arrive at an accurate total for the numerator and denominator of the measure. Previously CMS had advised providers to reconcile information so that they only reported unique patients. However, because it is not possible for providers to increase their overall percentage of actions taken by adding numerators and denominators from multiple systems, we now permit simple addition for all meaningful use objectives.

Please keep in mind that patients whose records are not maintained in certified EHR technology will need to be added to denominators whenever applicable in order to provide accurate numbers.

To report clinical quality measures, EPs who practice in multiple locations that are equipped with certified EHR technology should generate a report from each of those certified EHR systems and then add the numerators, denominators, and exclusions from each generated report in order to arrive at a number that reflects the total data output for patient encounters at those locations. To report clinical quality measures, eligible hospitals and CAHs that have multiple systems should generate a report from each of those certified EHR systems and then add the numerators, denominators, and exclusions from each generated report in order to arrive at a number that reflects the total data output for patient encounters in the relevant departments of the eligible hospital or CAH (e.g., inpatient or emergency department (POS 21 or 23)).

To view the final rule for the Medicare and Medicaid EHR incentive programs, please visit: http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10843

If an eligible professional (EP) sees a patient in a setting that does not have certified electronic health record (EHR) technology but enters all of the patient's information into certified EHR technology at another practice location, can the patient be counted in the numerators and denominators of meaningful use measures for the Medicare and Medicaid EHR Incentive Programs?

Yes for Stage 1, an EP may include patients seen in locations without certified EHR technology in the numerators and denominators of meaningful use measures if the patients' information is entered into certified EHR technology at another practice location. However, EPs should be aware

that it is unlikely that they will be able to include such patients in the numerator for the measure of the “use computerized provider order entry (CPOE)” objective or for the e-prescribing measure. As we explain in FAQ #10134, CPOE must be entered by someone who can exercise clinical judgment in the case that the entry generates any alerts about possible interactions or other clinical decision support aides. This necessitates that CPOE occurs when the order first becomes part of the patient's medical record and before any action can be taken on the order. Because information for patients seen in locations without certified EHR technology will be transcribed at a later date into the certified EHR system, it is unlikely that CPOE could occur before any action is taken on the order. For the e-prescribing measure, it is unlikely that EPs will be able to electronically transmit prescriptions for patients in locations without certified EHR technology.

When an EP starts Stage 2 of meaningful use, this is no longer the case and a location must be equipped with EHR Technology certified to the 2014 edition criteria for patients seen at that location to be counted.

Date Updated: 8/23/2012 New ID #3077 Old ID #10475

When eligible professionals work at more than one clinical site of practice, are they required to use data from all sites of practice to support their demonstration of meaningful use and the minimum patient volume thresholds for the Medicaid EHR Incentive Program?

CMS considers these two separate, but related issues.

Meaningful use: Any eligible professional demonstrating meaningful use must have at least 50% of their of their patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with certified EHR technology capable of meeting all of the meaningful use objectives. Therefore, States should collect information on meaningful users' practice locations in order to validate this requirement in an audit.

Patient volume: Eligible professionals may choose one (or more) clinical sites of practice in order to calculate their patient volume. This calculation does not need to be across all of an eligible professional's sites of practice. However, at least one of the locations where the eligible professional is adopting or meaningfully using certified EHR technology should be included in the patient volume. In other words, if an eligible professional practices in two locations, one with certified EHR technology and one without, the eligible professional should include the patient volume at least at the site that includes the certified EHR technology. When making an individual patient volume calculation (i.e., not using the group/clinic proxy option), a professional may calculate across all practice sites, or just at the one site. For more information on applying the group/clinic proxy option, see FAQ #10362 or click here.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10416

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Encounters

In order to meet the participation threshold of 50 percent of patient encounters in practice locations equipped with certified electronic health record (EHR) technology for the Medicare and Medicaid EHR Incentive Programs, how should patient encounters be calculated?

To be a meaningful EHR user, an EP must have 50 percent or more of their patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with certified EHR technology. For the purpose of calculating this 50 percent threshold, any encounter where a medical treatment is provided and/or evaluation and management services are provided should be considered a "patient encounter."

Please note that this is different from the requirements for establishing patient volume for the Medicaid EHR Incentive Program. You may wish to review those FAQs and other requirements related to Medicaid patient volume, since there is variation in what is considered to be a patient encounter.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10592

For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, should patient encounters in an ambulatory surgical center (Place of Service 24) be included in the denominator for calculating that at least 50 percent or more of an eligible professional's (EP's) patient encounters during the reporting period occurred at a practice/location or practices/locations equipped with certified EHR technology?

Yes. EPs who practice in multiple locations must have 50 percent or more of their patient encounters during the reporting period at a practice/location or practices/locations equipped with certified EHR technology. Every patient encounter in all Places of Service (POS) except a hospital inpatient department (POS 21) or a hospital emergency department (POS 23) should be included in the denominator of the calculation, which would include patient encounters in an ambulatory surgical center (POS 24).

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10466

For the Medicare and Medicaid EHR Incentive Programs, when a patient is only seen by a member of the eligible professional's (EP's) clinical staff during the EHR reporting period and not by the EP themselves, do those patients count in the EP's denominator?

The EP can include or not include those patients in their denominator at their discretion as long as the decision applies universally to all patients for the entire EHR reporting period and the EP is consistent across meaningful use measures. In cases where a member of the EP's clinical staff is eligible for the Medicaid EHR incentive in their own right (NPs and certain physician assistants (PA)), patients seen by NPs or PAs under the EP's supervision can be counted by both the NP or PA and the supervising EP as long as the policy is consistent for the entire EHR reporting period.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms

Keywords: FAQ10665

For eligible professionals (EPs) who see patients in both inpatient and outpatient settings (e.g., hospital and clinic), and where certified electronic health record (EHR) technology is available at each location, should these EPs base their denominators for meaningful use objectives on

the number of unique patients in only the outpatient setting or on the total number of unique patients from both settings?

In this case, EPs should base both the numerators and denominators for meaningful use objectives on the number of unique patients in the clinic setting, since this setting is where they are eligible to receive payments from the Medicare and Medicaid EHR Incentive Programs.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10068

How should patients in swing beds be counted in the denominators of meaningful use measures for eligible hospitals and critical access hospitals (CAHs) for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

A number of the meaningful use measures for eligible hospitals and CAHs require the denominator to be based on the number of unique patients admitted to the inpatient or emergency department during the EHR reporting period. Unique swing bed patients who receive inpatient care should be included in the denominators of meaningful use measures. However, if the eligible hospital or CAH's certified EHR technology cannot readily identify and include unique swing bed patients who have received inpatient care, those patients may be excluded from the calculations for the denominators of meaningful use measures.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10640

How should nursery day patients be counted in the denominators of meaningful use measures for eligible hospitals and critical access hospitals (CAHs) for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

Nursery days are excluded from the calculation of hospital incentives because they are not considered inpatient-bed-days based on the level of care provided during a normal nursery stay. In addition, nursery day patients should not be included in the denominators of meaningful use measures. However, if the eligible hospital or critical access hospital's (CAH's) certified EHR technology cannot readily identify and exclude nursery day patients, those patients may be included in the calculations for the denominators of meaningful use measures.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10641

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EHR Technology

If a provider purchases a certified Complete Electronic Health Record (EHR) or has a combination of certified EHR Modules that collectively satisfy the definition of certified EHR technology, but opts to use a different, uncertified EHR technology to meet certain meaningful use core or menu set objectives and measures, will that provider be able to successfully demonstrate meaningful use under the Medicare and Medicaid EHR Incentive Programs?

> No, the provider would not be able to successfully demonstrate meaningful use. To successfully demonstrate meaningful use, a provider must do three things:
>
> 1. Have certified EHR technology capable of demonstrating meaningful use, either through a complete certified EHR or a combination of certified EHR modules;
>
> 2. Meet the measures or exclusions for 20 Meaningful Use objectives (19 objectives for eligible hospitals and Critical Access Hospitals (CAHs)); and
>
> 3. Meet those measures using the capabilities and standards that were certified to accomplish each objective.
>
> A provider using uncertified EHR technology to meet one or more of the core or menu set measures would not be using the capabilities and standards that were certified to accomplish each objective. Please note that this does not apply to the use of uncertified EHR technology and/or paper-based records for purposes of reporting on certain meaningful use measures (i.e., measures other than clinical quality measures), which is addressed in FAQ #10589.
>
> For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.
>
> Keywords: FAQ10590

If a provider purchases a Complete Electronic Health Record (EHR) but opts to use alternate certified EHR modules for certain Meaningful Use functionality, will that provider qualify as a Meaningful User under the Medicare and Medicaid EHR Incentive Programs?

> To successfully demonstrate meaningful use a provider must do three things:
>
> 1. Have certified EHR technology capable of demonstrating meaningful use, either through a complete certified EHR or a combination of certified EHR modules;
>
> 2. Meet the measures or exclusions for 20 Meaningful Use objectives (19 objectives for eligible hospitals and Critical Access Hospitals (CAHs)); and
>
> 3. Meet those measures using the capabilities and standards that were certified to accomplish each objective.
>
> If a provider can meet all of these requirements, that provider may qualify for an incentive payment under the Medicare and Medicaid EHR Incentive Programs.
>
> For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.
>
> Keywords: FAQ10135

If a provider feeds data from certified electronic health record (EHR) technology to a data warehouse, can the provider report on Meaningful Use objectives and clinical quality measures from the data warehouse?

To be a meaningful EHR user a provider must do three things:

Have complete certified EHR technology for all meaningful use objectives either through a complete EHR or a combination of modules; and Meet 20 measures (19 for eligible hospitals and CAHs), including all of the core and five (5) menu-set measures associated with the objectives (unless excluded). Core measures include reporting clinical quality measures. Use the capabilities and standards of certified EHR technology in meeting the measure of each objective

If the conditions above are met and data is transferred from the certified EHR technology to a data warehouse, the provider can use information from the data warehouse to report on Meaningful Use objectives and clinical quality measures. However, in order to report calculated clinical quality measures, the data warehouse may need to be certified. The Office of the National Coordinator of Health Information Technology has addressed the issue of certification of a data warehouse in the following Frequently Asked Question: http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3163&PageID=20775.

For more information about certification, you can contact ONC directly at onc.certification@hhs.gov.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10153

If data is captured using certified electronic health record (EHR) technology, can an eligible professional or eligible hospital use a different system to generate reports used to demonstrate meaningful use for the Medicare and Medicaid EHR Incentive Programs?

By definition, certified EHR technology must include the capability to electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage for all percentage-based meaningful use measures (specified in the certification criterion adopted at 45 CFR 170.302(n)). However, the meaningful use measures do not specify that this capability must be used to calculate the numerators and denominators. Eligible professionals and eligible hospitals may use a separate, non-certified system to calculate numerators and denominators and to generate reports on the measures of the core and menu set meaningful use objectives.

Eligible professionals and eligible hospitals will then enter this information in CMS' web-based Medicare and Medicaid EHR Incentive Program Registration and Attestation System. Eligible professionals and eligible hospitals will fill in numerators and denominators for meaningful use objectives, indicate if they qualify for exclusions to specific objectives, report on clinical quality measures, and legally attest that they have successfully demonstrated meaningful use.

Please note that eligible professionals and eligible hospitals cannot use a non-certified system to calculate the numerators, denominators, and exclusion information for clinical quality measures. Numerator, denominator, and exclusion information for clinical quality measures must be reported directly from certified EHR technology. For additional clarification about this, please refer to the following FAQ from the Office of the National Coordinator of Health Information Technology: http://healthit.hhs.gov/portal/server.pt/community/onc_regulations_faqs/3163/faq_13/20775.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10465

Must providers have their electronic health record (EHR) technology certified prior to beginning the EHR reporting period in order to demonstrate Meaningful Use under the Medicare and Medicaid EHR Incentive Programs?

No. An EP or hospital may begin the EHR reporting period for demonstrating Meaningful Use before their EHR technology is certified. Certification need only be obtained prior to the end of the EHR reporting period. However, Meaningful Use must be completed using the capabilities and standards outlined in the ONC Standards and Certification Regulation for certified EHR technology. Any changes to the EHR technology after the beginning of the EHR reporting period that are made in order to get the EHR technology certified would be evidence that the provider was not using the capabilities and standards necessary to accomplish Meaningful Use because those capabilities and standards would not have been available, and thus, any such change (no matter how minimal) would disqualify the provider from being a meaningful EHR user. If providers begin the EHR reporting period prior to certification of their EHR technology, they are taking the risk that their EHR technology will not require any changes for certification. Any changes made to gain certification must be done prior to the beginning of the EHR reporting period during which Meaningful Use will be demonstrated. This does not apply to changes made to EHR technology that were not necessary for certification.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10157

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Objectives and Clinical Quality Measures—General Principles

My practice does not typically collect information on any of the core, alternate core, and additional clinical quality measures (CQMs) listed in the Final Rule on the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. Do I need to report on CQMs for which I do not have any data?

EPs are not excluded from reporting clinical quality measures, but zero is an acceptable value for the CQM denominator. If there were no patients who met the denominator population for a CQM, then the EP would report a zero for the denominator and a zero for the numerator. For the core measures, if the EP reports a zero for the core measure denominator, then the EP must report results for up to three alternate core measures (potentially reporting on all 6 core/alternate core measures). For the menu-set measures, we expect the EP to report on measures which do not have a denominator of zero. If none of the measures in the menu set applies to the EP, then the EP must report on three of such measures, reporting a denominator of zero, and then attest that the remainder of the menu-set measures have a value of zero in the denominator. As we stated in the final rule (75 FR 44409-10): "The expectation is that the EHR will automatically report on each core clinical quality measure, and when one or more of the core measures has a denominator of zero then the alternate core measure(s) will be reported. If all six of the clinical quality measures in Table 7 have zeros for the denominators (this would imply that the EPs patient population is not addressed by these measures), then the EP is still required to report on three additional clinical measures of their choosing from Table 6 in this final rule. In regard to the three additional clinical quality measures, if the EP reports zero values, then for the remaining clinical quality measures in Table 6 (other than the core and alternate core measures) the EP will have to attest that all of the other clinical quality measures calculated by the certified EHR technology have a value of zero in the denominator, if the EP is to be exempt from reporting any of the additional clinical quality measures (other than the core and alternate core measures) in Table 6."

To view the final rule, please visit: http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10072

Does a provider have to record all clinical data in their certified EHR technology in order to accurately report complete clinical quality measure data for the Medicare and Medicaid EHR Incentive Programs?

We recognize that providers are continuing to implement new workflow processes to accurately capture clinical data in their certified EHR technology, but many providers are not able to capture all data at this time. Although we encourage providers to capture complete clinical data in order to provide the best care possible for their patients, for the purpose of reporting clinical quality measure data, CMS does not require providers to record all clinical data in their certified EHR technology at this time. CMS recognizes that this may yield numerator, denominator, and exclusion values for clinical quality measures in the certified EHR technology that are not identical to the values generated from other methods (such as record extraction). However, at this time CMS requires providers to report the clinical quality measure data exactly as it is generated as output from the certified EHR technology in order to successfully demonstrate meaningful use. We will continue to collaborate with our partners in the Office of the National Coordinator for Health Information Technology and with industry stakeholders to make further headways in system interoperability, standards for EHR data, as well as certification of vendor products.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10839

For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, if certified EHR technology possessed by an eligible professional (EP) includes the ability to calculate

clinical quality measures (CQMs) from the additional set that are not indicated by the EHR developer or on the Certified Health Information Technology Product List (CHPL) as tested and certified by an ONC - Authorized Testing and Certification Body (ONC-ATCB), can the EP submit the results of those CQMs to CMS as part of their meaningful use attestation?

> Yes, the EP can submit results for CQMs in the additional set (Table 6 of the final rule) calculated by certified EHR technology, even if those CQMs were not individually tested and certified by an ONC-ATCB. We expect to revisit CQM requirements in more detail for later stages of meaningful use as well as the corresponding certification requirements.
>
> To view the final rule for the Medicare and Medicaid EHR incentive programs, please visit: http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf.
>
> For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.
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> Keywords: FAQ10649

I am an eligible professional (EP) for whom none of the core, alternate core, or additional clinical quality measures adopted for the Medicare and Medicaid Electronic Health Record (EHR) incentive programs apply. Am I exempt from reporting on all clinical quality measures?

> In the event that none of the 44 clinical quality measures applies to an EP's patient population, the EP is still required to report a zero for the denominators for all six of the core and alternate core clinical quality measures. If all of the remaining 44 clinical quality measures included in Table 6 of our final rule do not apply to the EP, then the EP is still required to report on at least three of the additional clinical quality measures of their choosing from Table 6 of the final rule (other than the six core/alternative core measures). If the EP reports zero values for these three additional, menu-set clinical quality measures, then for the remaining menu-set clinical quality measures, the EP will also have to attest that all the other menu-set quality measures calculated by the certified EHR technology have a value of zero in the denominator. In other words, the EP is required is required to try to find at least three measures in the menu set for which the denominator is other than zero. If s/he cannot, then the EP must still choose three menu-set measures on which to report. S/he may report zero denominators for some or all of these measures, but must accompany such "zero denominator" reporting with an attestation that all of the other menu-set measures calculated by the certified EHR technology have a value of zero in the denominator. A zero report in the menu-set is not sufficient without such accompanying attestation. We refer readers to page 44410 of the preamble to the final rule.
>
> To view the final rule for the Medicare and Medicaid EHR incentive programs, please visit: http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf
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> For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.
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> Keywords: FAQ10144

One of the measures for the core set of clinical quality measures for eligible professionals (EPs) is not applicable for my patient population. Am I excluded from reporting that measure for the Medicare or Medicaid Electronic Health Record (EHR) Incentive Programs?

> An eligible professional (EP) is not excluded from reporting core clinical quality measures. However, zero is an acceptable value to report for the denominator of a clinical quality measure if there is no patient population within the EHR to whom that clinical quality measure applies. If an EP reports a zero denominator for one of the core measures, then the EP is required to report results for up to three alternate core measures (possibly reporting denominators of 0 for all three alternate core measures). We refer readers to pp. 44409-10 of the preamble to our final rule for our discussion of this issue.
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> To view the final rule for the Medicare and Medicaid EHR incentive programs, please visit: http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10142

For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, if the certified EHR technology possessed by an eligible professional (EP) generates zero denominators for all clinical quality measures (CQMs) in the additional set that it can calculate, is the EP responsible for determining whether they have zero denominators or data for any remaining CQMs in the additional set that their certified EHR technology is not capable of calculating?

No, the EP is not responsible for determining the status of CQMs that their certified EHR technology is not capable of calculating. The certification criterion for ambulatory CQMs sets a minimum threshold in order for the certification criterion to be met. A 2011 edition EHR technology must be certified to the 6 core CQMs (3 core and 3 alternate core CQMs in Table 7 of the Stage 1 final rule) and at least 3 CQMs from the additional set (Table 6 of the Stage 1 final rule). In the Stage 1 final rule, we stated that it was our expectation that EPs would seek out certified EHR technologies that include and were certified for CQMs relevant to their scope of practice. Starting in 2014, EPs will have 2014 edition EHR technology which has different criteria. This FAQ applies only through the end of 2013.

To view the Stage 1 final rule for the Medicare and Medicaid EHR incentive programs, please visit: http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf.

Date Updated: 8/23/2012 New ID #3275 Old ID #10648

For eligible hospitals and critical access hospitals (CAHs) under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, will the clinical quality measure results be calculated similar to the Hospital Inpatient Quality Reporting (IQR) Program (Formerly known as Reporting Hospital Quality Data for Annual Payment Update program)?

No. For all clinical quality measures reported for the Medicare and Medicaid EHR Incentive Programs, the certified EHR must report the numerator, denominator, and exclusion results. Providers will report their aggregate results for clinical quality measures during attestation to CMS or the States.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit: http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10146

Do specialty providers have to meet all of the meaningful use objectives for the Medicare and Medicaid EHR Incentive Programs, or can they ignore the objectives that are not relevant to their scope of practice?

For eligible professionals (EPs) who participate in the Medicare and Medicaid EHR Incentive Programs, there are a total of 25 meaningful use objectives. To qualify for an incentive payment, 20 of these 25 objectives must be met. There are 15 required core objectives. The remaining 5 objectives may be chosen from the list of 10 menu set objectives. Certain objectives do provide exclusions. If an EP meets the criteria for that exclusion, then the EP can claim that exclusion during attestation. However, if an exclusion is not provided, or if the EP does not meet the criteria for an existing exclusion, then the EP must meet the measure of the objective in order to successfully demonstrate meaningful use and receive an EHR incentive payment. Failure to meet the measure of an objective or to qualify for an exclusion for the objective will prevent an EP from successfully demonstrating meaningful use and receiving an incentive payment.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10469

What are the requirements for dentists participating in the Medicaid EHR Incentive Program?

Dentists must meet the same eligibility requirements as other eligible professionals (EP) in order to qualify for payments under the Medicaid EHR Incentive Program. This also means that they must demonstrate all 15 of the core meaningful use objectives and five from the menu of their choosing. The core set includes reporting of six clinical quality measures (three core and three from the menu of their choosing.) Several meaningful use objectives have exclusion criteria that are unique to each objective. EPs will have to evaluate whether they individually meet the exclusion criteria for each applicable objective as there is no blanket exclusion by type of EP.

Date Updated: 9/12/2012 New ID #3109 Old ID #10527

For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, how should an eligible hospital or critical access hospital (CAH) with multiple certified EHR systems report their clinical quality measures?

To report clinical quality measures, eligible hospitals and CAHs that have multiple systems should generate a report from each of those certified EHR systems and then add the numerators, denominators, and exclusions from each generated report in order to arrive at a number that reflects the total data output for patient encounters in the relevant departments of the eligible hospital or CAH (e.g., inpatient or emergency department (POS 21 or 23)).

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10844

For the Medicare and Medicaid EHR Incentive Programs' clinical quality measures (CQMs) ED-1, ED-2, and Stroke-4, how should eligible hospitals and critical access hospitals (CAHs) define an Emergency Department patient since the UB-04 data set referred to in the HITSP specifications no longer provides this information?

The measure steward recommends that hospitals use the data element 'ED Patient', defined as any patient receiving care or services in the Emergency Department. This data element specification to be used for ED-1, ED-2, and Stroke-4 can be found at http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228767363466 in Section 1 Data Dictionary/Alphabetical Data Dictionary (page 1-146).

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10883

For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, does an eligible hospital have to count patients admitted to both the inpatient and emergency departments in the denominator of meaningful use measures, or can they count only emergency department patients?

For the hospital meaningful use objectives, the denominator is all unique patients admitted to an inpatient (POS 21) or emergency department (POS 23), which means all patients admitted to an inpatient department (POS 21) and all patients admitted to an emergency department (POS 23). If the eligible hospital elects to use the alternate method for calculating emergency department

patients, as detailed in FAQ #10126 (http://questions.cms.hhs.gov/app/answers/detail/a_id/10126/kw/ed), the denominator is all unique patients admitted to an inpatient department (POS 21) and all patients that initially present to the emergency department and are treated in the emergency department's observation unit or otherwise receive observation services, which includes patients who receive observation services under both POS 22 and POS 23. Patients admitted to the inpatient department must be included in the denominator of all applicable measures.

Date Updated: 9/4/2012 New ID #3067 Old ID #10468

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Specific Measures

CPOE

Who can enter medication orders in order to meet the measure for the computerized provider order entry (CPOE) meaningful use objective under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs? When must these medication orders be entered?

> Any licensed healthcare professional can enter orders into the medical record for purposes of including the order in the numerator for the measure of the **CPOE** objective if they can enter the order per state, local, and professional guidelines. The order must be entered by someone who could exercise clinical judgment in the case that the entry generates any alerts about possible interactions or other clinical decision support aides. This necessitates that **CPOE** occurs when the order first becomes part of the patient's medical record and before any action can be taken on the order. Each provider will have to evaluate on a case-by-case basis whether a given situation is entered according to state, local, and professional guidelines, allows for clinical judgment before the medication is given, and is the first time the order becomes part of the patient's medical record.
>
> For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.
>
> Keywords: FAQ10134

For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, how should an eligible professional (EP) who orders medications infrequently calculate the measure for the "computerized provider order entry (CPOE)" objective if the EP sees patients whose medications are maintained in the medication list by the EP but were not ordered or prescribed by the EP?

> The CPOE measure is structured to minimize reporting burden. However, if all of the following conditions are met it can also create a unique situation that could prevent an EP from successfully demonstrating meaningful use. An EP who:
> prescribes more than 100 medications during the EHR reporting period; maintains medication lists that include medications that they did not order; and orders medications for less than 30 percent of patients with a medication in their medication list during the EHR reporting period.
> In these circumstances, an EP may be both unable to meet this measure and unable to qualify for the exclusion. In the unique situation where all three criteria listed above apply, an EPs may limit their denominator to only those patients for whom the EP has previously ordered medication, if they so choose. EPs who do not meet the three criteria listed above must still base their calculation on the number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period regardless of who ordered the medication or medications in the patient's medication list.
>
> For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.
>
> Keywords: FAQ10639

To meet the meaningful use objective "use computerized provider order entry (CPOE)" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, should eligible professionals (EPs) include hospital-based observation patients (billed under POS 22) whose records are maintained using the hospital's certified EHR system in the numerator and denominator calculation for this measure?

> If the patient has records that are maintained in both the hospital's certified EHR system and the EP's certified EHR system, the EP should include those patients seen in locations billed under POS 22 in the numerator and denominator calculation for this measure. If the patient's records are maintained only in a hospital certified EHR system, the EP does not need to include those patients in the numerator and denominator calculation to meet the measure of the "use computerized provider order entry (CPOE)" objective.

For more information about the Medicare and Medicaid EHR Incentive Program, please visithttp://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10462

Generate and Transmit Permissible Prescriptions Electronically

For the meaningful use objective of "generate and transmit prescriptions electronically (eRx)" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program, how should the numerator and denominator be calculated? Should electronic prescriptions fulfilled by an internal pharmacy be included in the numerator?

The denominator for this objective consists of the number of prescriptions written for drugs requiring a prescription in order to be dispensed, other than controlled substances, during the EHR reporting period. The numerator consists of the number of prescriptions in the denominator generated and transmitted electronically using certified EHR technology. In order to meet the measure of this objective, 40 percent of all permissible prescriptions written by the EP must be generated and transmitted electronically according to the applicable certification criteria and associated standards adopted for certified EHR technology as specified by the Office of the National Coordinator for Health IT (ONC).

ONC has released an FAQ stating that "with respect to the capability a Complete EHR or EHR Module must demonstrate in order to be certified to the certification criterion adopted at 170.304(b), a Complete EHR or EHR Module must be capable of electronically transmitting prescriptions to external recipients according to NCPDP SCRIPT 8.1 or 10.6 in addition to the adopted vocabulary standard for medications (45 CFR 170.207(d))." Given such FAQ, prescriptions transmitted electronically within an organization (the same legal entity) would not need to use these NCPDP standards. However, an EP's EHR must meet all applicable certification criteria and be certified as having the capability of meeting the external transmission requirements of §170.304(b). In addition, the EHR that is used to transmit prescriptions within the organization would need to be Certified EHR Technology.

The EP would include in the numerator and denominator both types of electronic transmissions (those within and outside the organization) for the measure of this objective. We further clarify that for purposes of counting prescriptions "generated and transmitted electronically," we consider the generation and transmission of prescriptions to occur simultaneously if the prescriber and dispenser are the same person and/or are accessing the same record in an integrated EHR to creating an order in a system that is electronically transmitted to an internal pharmacy.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10284

Do controlled substances qualify as "permissible prescriptions" for meeting the electronic prescribing (eRx) meaningful use objective under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

The term "permissible prescriptions" refers to the restrictions that were established by the Department of Justice (DOJ) on electronic prescribing (eRx) for controlled substances in Schedule II-V. (The substances in Schedule II-V can be found at http://www.deadiversion.usdoj.gov/schedules/orangebook/e_cs_sched.pdf). Any prescription not subject to these restrictions would be a permissible prescription. Although DOJ recently published an Interim Final Rule that allows the electronic prescribing of these substances, we were unable to incorporate these recent guidelines into the Medicare and Medicaid EHR Incentive Programs. Therefore, the determination of whether a prescription is a "permissible prescription" for purposes of the eRx meaningful use objective should be made based on the guidelines for prescribing Schedule II-V controlled substances in effect on or before January 13, 2010, when the notice of proposed rulemaking was published in the Federal Register.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit: http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10067

Record Demographics

For the meaningful use objective of "record demographics" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program, what documentation is required when recording the preliminary cause of death in the event of mortality?

Eligible hospitals and critical access hospitals (CAHs) must record in the patient's EHR the clinical impression and preliminary assessment of the cause of death. No further documentation is required. This measure does not require the cause of death to be updated if the case is referred to the Department of Health or coroner's office.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10165

Record and Chart Changes in Vital Signs

In recording height as part of the core Meaningful Use objective "Recording vital signs" for eligible professionals (EPs), eligible hospitals, and Critical Access Hospitals (CAHs), how should providers account for patients who are too sick or otherwise cannot be measured safely?

In cases where taking an actual height measurement is inappropriate, self-reported or estimated height can be used.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10156

For the meaningful use objective to "record and chart changes in vital signs" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, can an eligible professional (EP) claim an exclusion if the EP regularly records only one or two of the required vital signs but not all three?

An exclusion for this objective is provided only for EPs who either see no patients 2 years or older, or who believe that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice. If an EP believes that one or two of these vital signs are relevant to their scope of practice, then they must record all three vital signs in order to meet the measure of this objective and successfully demonstrate meaningful use.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10593

Provide Patients with an Electronic Copy of Health Information

To meet the meaningful use objective "provide patients with an electronic copy of their health information" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, how should the numerator and denominator be calculated for patients who see multiple eligible professionals (EPs) in the same practice (e.g., in a multi-specialty group practice)?

If the request for an electronic copy of their health information is made by a patient to a specific EP, then the patient should be counted in the numerator and denominator for that specific EP. If the patient makes a request for an electronic copy of their health information that is not to a

specific EP (e.g., by request to the practice's administrative staff), then the patient should be counted in the numerators and denominators for all EPs with whom the patient has had an office visit.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10269

Provide Clinical Summaries

If a patient visit spans several days and the patient is seen by multiple eligible professionals (EPs) during that time period, does each EP need to provide a separate clinical summary or can the provision of a single clinical summary at the end of the visit meet the meaningful use objective for "provide clinical summaries for patients after each office visit" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

When a patient visit lasts several days and the patient is seen by multiple EPs, a single clinical summary at the end of the visit can be used to meet the meaningful use objective for "provide clinical summaries for patients after each office visit."

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10166

Exchange Key Clinical Information

To meet the meaningful use objective “capability to exchange key clinical information” for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, can different providers of care (e.g., physicians, hospitals, etc.) share EHR technology and successfully meet this objective?

In order to meet this objective, clinical information must be sent between different legal entities with distinct certified EHR technology and not between organizations that share a certified EHR technology or organizations that are part of the same legal entity, since no actual exchange of clinical information would take place in these latter instances. Distinct certified EHR technologies are those that can achieve certification and operate independently of other certified EHR technologies. It is possible for different legal entities to meet this objective by using separate instances of the same certified EHR technology (e.g. both entities using separate license of the same program), subject to the following limitations:

• A different legal entity is an entity that has its own separate legal existence. Indications that two entities are legally separate would include (1) they are each separately incorporated; (2) they have separate Boards of Directors; and (3) neither entity is owned or controlled by the other.

• In order to be distinct certified EHR technology, each instance of certified EHR technology must be able to be certified and operate independently from all others. Separate instances of certified EHR technology that must link to a common database in order to gain certification would not be considered distinct. However, instances of certified EHR technology that link to a common, uncertified system or component would be considered distinct. Instances of certified EHR technology can be from the same vendor and still be considered distinct.

• The exchange of key clinical information requires that the eligible professional, eligible hospital, or critical access hospital (CAH) must use the standards of certified EHR technology as specified by the Office of the National Coordinator for Health IT, not the capabilities of uncertified or other vendor-specific alternative methods for exchanging clinical information.

Keywords: FAQ10270

For the meaningful use objective of "capability to exchange key clinical information" in the Medicare and Medicaid EHR Incentive Programs, what forms of electronic transmission can be used to meet the measure of the objective?

For the purposes of the "capability to exchange key clinical information" measure, exchange is defined as electronic transmission and acceptance of key clinical information using the capabilities and standards of certified EHR technology (as specified at 45 CFR 170.304(i) for eligible professionals and 45 CFR 170.306(f) for eligible hospitals and cricitcal access hospitals). There are many acceptable transmission methods for conducting a test of the electronic exchange of key clinical information with providers of care and patient authorized entities (see FAQ #) To meet the measure of this objective a provider must:
use certified EHR technology to generate a continuity of care document (CCD)/continuity of care record (CCR), and electronically transmit the CCD/CCR.
To complete step 2, an eligible professional, eligible hospital, or critical access hospital may use any means of electronic transmission according to any transport standard(s) (SMTP, FTP, REST, SOAP, etc.) regardless of whether it was included by an EHR technology developer as part of the certified EHR technology in the eligible professional's, eligible hospital's, or critical access hospital's possession.

Please note that the use of USB, CD-ROM, or other physical media or electronic fax would not meet the measure of this objective and has been addressed in another FAQ (see FAQ #10638) If the test involves the transmission of actual patient information, all current privacy and security regulations must be met.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10691

For the Stage 1 meaningful use objective of "capability to exchange key clinical information" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, does exchange of electronic information using physical media, such as USB, CD-ROM, or other formats, meet the measure of this objective?

No, the use of physical media such as a CD-ROM, a USB or hard drive, or other formats to exchange key clinical information would not utilize the certification capability of certified EHR technology to electronically transmit the information, and therefore would not meet the measure of this objective.

For the purposes of the Stage 1 "capability to exchange key clinical information" measure, exchange is defined as electronic transmission and acceptance of key clinical information using the capabilities and standards of certified EHR technology (as specified at 45 CFR 170.304(i) for EPs and 45 CFR 170.306(f) for eligible hospitals and CAHs). We expect that this information would be exchanged in structured electronic format when available (e.g., drug or clinical lab data); however, where the information is available only in unstructured electronic formats (e.g., free text or scanned images), the exchange of unstructured information would satisfy this measure. For more information about electronic exchange of key clinical information, please refer to the following FAQ: http://questions.cms.hhs.gov/app/answers/detail/a_id/10270/kw/10270.

Please note that this objective is distinct from objectives such as "provide a summary of care record for each transition of care," where electronic exchange of the summary of care record is not a requirement but an option. To satisfy the measure of the "provide a summary of care record for each transition of care" objective, a provider is permitted to send an electronic or paper copy of the summary care record directly to the next provider or can provide it to the patient to deliver. In this case, the use of physical media such as a CD-ROM, a USB or hard drive, or other formats could satisfy the measure of this objective.

Effective 2013, this objective and measure are no longer required.

Date Updated: 8/23/2012 New ID #3255 Old ID #10638

For meaningful use objectives of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs that require a provider to test the transfer of data, such as "capability to exchange key clinical information" and testing submission of data to public health agencies, if multiple eligible professionals (EPs) are using the same certified EHR technology across several physical locations, can a single test serve to meet the measures of these objectives?

No, if multiple EPs are using the same certified EHR technology in different physical locations/settings (e.g., different practice locations), there must be a single test performed for each physical location/setting. This is true even if the certified EHR technology that is used in the different physical locations is connected to the same server. The purpose of this testing is to demonstrate that the information can be transferred from where it was created (the physical location/setting of the EP or group of EPs) to another provider of care, patient-authorized entity or public health agency. While we understand that several different physical locations/settings may send this information through a central server or on mostly the same path, there may be some degree of variation in the path of transmission or the infrastructure involved.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10979

For meaningful use objectives of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs that require a provider to test the transfer of data, such as "capability to exchange key clinical information" and testing submission of data to public health agencies, can the eligible professional (EP), eligible hospital or critical access hospital (CAH) conduct the test from a test environment or test domain of its certified EHR technology in order to satisfy the measures of these objectives?

Yes, it is acceptable to conduct a test of information exchange from a test environment or test domain of certified EHR technology in order to satisfy the measures of the objective for "capability to exchange key clinical information" or any of the public health objectives (e.g., immunization registry, syndromic surveillance, or reportable lab results). A provider can also use simulated data when conducting these tests-the use of test information about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy these objectives.

However, it is important to note that in order to meet the objective for "capability to exchange key clinical information," the provider must conduct the test with another provider of care with distinct certified EHR technology or other system capable of receiving the information. Simulated transfers of information or transfers of information through means that do not reach another provider of care (e.g., "dummy" websites that exist solely for providers to send information) are not acceptable to satisfy this objective.

Similarly, to meet any of the public health objectives, the provider's test must involve the actual submission of information to public health agencies, and follow up submission is required if the test is successful. Please note that some public health agencies will not allow providers to submit test information about fictional patients. Providers submitting information to public health agencies that do not allow test information must submit actual patient information as a test in order to satisfy the measures of these objectives.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10978

For the "Incorporate clinical lab-test results" menu objective of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, how should a provider attest if the numerator displayed by their certified EHR technology is larger than the denominator?

> For the "Incorporate clinical lab-test results" menu objective, a provider's certified EHR technology might return a numerator larger than the denominator if the EHR does not match lab orders to results on a one-for-one basis or if the EHR records a panel that returns multiple lab results as a single order within the system. However, the CMS EHR Incentive Programs Attestation System will not allow an eligible professional, eligible hospital, or critical access hospital (CAH) to input a numerator that is greater than the denominator. In the case where your certified EHR technology reports a numerator larger than the denominator, you should input a numerator equal to your denominator in the Attestation System. However, notwithstanding the numerator and denominator values that are entered into the Attestation System, a provider must actually surpass the 40% threshold to meet the measure of this objective. You should maintain documentation regarding the numerator and denominator values generated by your certified EHR technology and, in the event of an audit, be prepared to demonstrate that you satisfied the percentage threshold for this measure.
>
> For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.
>
> Keywrods: FAQ10981

What lab tests should be included in the denominator of the measure for the "incorporate clinical lab-test results" objective under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

> For the "incorporate clinical lab-test results" objective, the denominator consists of the number of lab tests ordered during the EHR reporting period by the eligible professional (or authorized providers of the eligible hospital or critical access hospital (CAH) for patients admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 and 23)) whose results are expressed in a positive or negative affirmation or as a number. Providers may limit the denominator to only those lab tests that were ordered during the EHR reporting period and for which results were received during the same EHR reporting period.
>
> For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.
>
> Keywords: FAQ10642

Identify Patient-Specific Resources

To meet the meaningful use objective "use certified EHR technology to identify patient-specific resources and provide those resources to the patient" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, does the certified EHR have to generate the education resources or can the EHR simply alert the provider of available resources?

> In the patient-specific education resources objective, education resources or materials do not have to be stored within or generated by the certified EHR. However, the provider should utilize certified EHR technology in a manner where the technology suggests patient-specific educational resources based on the information stored in the certified EHR technology. The provider can make a final decision on whether the education resource is useful and relevant to a specific patient.
>
> For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.
>
> Keywords: FAQ10164

Transition of Care Summary

For the meaningful use objective of "provide summary care record for each transition of care or referral " for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, should transitions of care between eligible professionals (EPs) within the same practice who share certified EHR technology be included in the numerator or denominator of the measure?

No, patients who transition between EPs within the same practice and who share the same certified EHR technology should not be included in the numerator or denominator of the measure of this objective. Since these transitions occur within the same practice between EPs who share certified EHR technology, they do not meet the definition of transition of care as the movement of a patient from one setting of care (for example, hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another. Also, because EPs sharing the same certified EHR technology already have complete access to the patient's electronic record, providing a summary of care document would serve no purpose. Therefore these patients should be excluded from the calculation of this measure.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10980

Submit Electronic Data to Immunization Registries

If my certified EHR technology only includes the capability to submit information to an immunization registry using the HL7 2.3.1 standard but the immunization registry only accepts information formatted in the HL7 2.5.1 or some other standard, will I qualify for an exclusion because the immunization registry does not have the capacity to receive the information electronically? What if the immunization registry has a waiting list or is unable to test for other reasons but can accept information formatted in HL7 2.3.1, is that still a valid exclusion?

If the immunization registry does not accept information in the standard to which your EHR technology has been certified-that is, if your EHR is certified to the HL7 2.3.1 standard and the immunization registry only accepts HL7 2.5.1, or vice versa-and if the immunization registry is the only immunization registry to which you can submit such information, then you can claim an exclusion to this Meaningful Use objective because the immunization registry does not have the capacity to receive the information electronically. The capacity of the immunization registry is determined by the ability of the immunization registry to test with an individual EP or eligible hospital. An immunization registry may have the capacity to accept immunization data from another EP or hospital, but if for any reason (e.g. waiting list, on-boarding process, other requirements, etc) the registry cannot test with a specific EP or hospital, that EP or hospital can exclude the objective. It is the responsibility of the EP or hospital to document the justification for their exclusion (including making clear that the immunization registry in question is the only one it can submit information to). If the immunization registry, due to State law or policy, would not accept immunization data from you (e.g., not a lifespan registry, etc), you can also claim the exclusion for this objective. Please note, this FAQ applies in principle to all of the Stage 1 public health meaningful use measures (syndromic surveillance and reportable lab conditions).

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10714

If my certified electronic health record (EHR) technology is capable of submitting batch files to an immunization registry using the standards adopted by the Office of the National Coordinator of Health Information Technology (HL7 2.3.1 or 2.5.1, and CVX), is that sufficient to meet the Meaningful Use objective "submit electronic data to immunization registries" for the Medicare and Medicaid EHR Incentive Programs?

Submitting batch files to an immunization registry, provided that they are formatted according to the standards adopted by the Office of the National Coordinator of Health Information Technology, is sufficient to meet the Meaningful Use objective "submit electronic data to immunization registries."

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10713

To meet the Stage 1 public health meaningful use objectives (submitting information to an immunization registry, reporting lab results to a public health agency, or reporting syndromic surveillance information) for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, does a provider have to send information directly from their certified EHR technology to the appropriate receiving entity or can they use an intermediary such as a health information exchange (HIE) or another third-party software vendor?

CMS recognizes that there are a variety of methods in which the exchange of public health information could take place. In order to promote the submission of public health information to appropriate entities, we do not seek to limit or define the receiving capacities of said entities. In order to satisfy the public health meaningful use objectives, a provider must conduct one test of information exchange according to the following criteria:

The information required for the public health meaningful use objective must originate from the provider's certified EHR technology; and

The information sent from the provider's certified EHR technology must be formatted according to the standards and implementation specifications associated with the public health meaningful use objective.

If an intermediary performs a capability specified in an adopted certification criterion and a provider intends to use the capability the intermediary provides to satisfy a correlated meaningful use requirement (submission to public health according to adopted standards), the capability provided by the intermediary would need to be certified as an EHR Module (see ONC FAQ 18 for more information).

Date Updated: 8/23/2012 New ID #3461 Old ID #10764 ·

Submit Data on Syndromic Surveillance

For the meaningful use objective "Capability to submit electronic syndromic surveillance data to public health agencies," what is the definition of "syndromic surveillance"?

Syndromic surveillance uses individual and population health indicators that are available before confirmed diagnoses or laboratory confirmation to identify outbreaks or health events and monitor the health status of a community. For additional information about syndromic surveillance data, please visit: http://www.cdc.gov/EHRmeaningfuluse/Syndromic.html.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: 10846

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